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ABSTRACT

Unique challenges surface when providing services in community mental health centers for persons with mental retardation and mental illness. Before any type of mental health treatment for a client with this dual diagnosis can begin, proper assessment is critical. Clinicians working with this population have to adapt their treatment strategies and assessments to the cognitive level of their clients. In addition, persons with mental retardation rarely seek out treatment on their own. Using a personal psychotherapy/counseling perspective, counselors need to carefully build relationship components which include the essential attributes of genuiness, empathy, and unconditional positive regard. In addition to a strong therapeutic relationship, the counseling environment must be seen as supportive, beginning with the initial interview. Key factors include setting a positive emotional tone for interactions, responsive and active listening, labeling feelings, and interpreting in understandable ways the client's statements and feelings expressed. The highly verbal nature of the counseling process is an important factor to consider when working with clients who may have limited or no verbal abilities due to their level of cognitive impairment. Specific types of therapies are examined. Education for mental health service providers treating these clients is strongly recommended. Contains 22 references. (JBJ)

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Running head: DUAL DIAGNOSIS

Special Considerations When Providing Mental Health Services for Persons with Mental Retardation

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Abstract

Unique challenges surface when providing services in community mental health centers for persons with mental retardation and mental illness. For these clients, proper assessment, a strong therapeutic relationship, concrete levels of communication, and effective therapies are even more critical than when treating clients with normal ranges of intellectual functioning. Education for mental health service providers treating these clients is strongly recommended.

Special Considerations When Providing Mental Health Services for Persons with Mental Retardation

In today's changing society, mental health professionals are increasingly being called upon in communities to embrace and uphold the concepts of pluralism and diversity. England (1992) noted that we, as counselors and service providers, are the "human-concern providers" for all those with special needs within our communities (p. 89).

One special population that has often been overlooked when mental health professionals speak of pluralism and diversity are those persons with an accompanying diagnosis of mental retardation in addition to a diagnosis of a mental illness. The demand for community mental health services for this special population is growing due to legal mandates, such as the Americans with Disabilities Act, as well as the increased recognition that persons with mental retardation present with high rates of accompanying mental illnesses (American Psychiatric Association Task Force, 1991). Matson (1992) indicated that dual diagnosis issues (mental retardation/mental illness) will continue to be a primary area of mental health concern through this century at least. Matson (1992) suggested persons with mental retardation are five times more likely to experience mental disorders than are persons with normal ranges of intellectual functioning in the population at large.

Compounding this need, the closing or reduction of state residential facilities for persons with mental retardation has resulted in a population of potentially behaviorally disturbed or emotionally disturbed individuals now seeking mental health services within communities. For example, this author provided psychological services at the South Dakota Developmental Center at Redfield, South Dakota which is a large state facility for persons with mental retardation. According to records, this facility had a population of

approximately 1200 clients in 1963; the population there in 1996 is approximately 250 clients. The clients who have left over the years due to deinstitutionalization are now residents of communities throughout the state. Their varying needs for mental health services still continue, however. The problem arises when such communities often lack mental health service providers properly trained in how to treat clients with this dual diagnosis (Beasley, Kroll, & Sovner, 1992).

The Assessment Process

Before any type of mental health treatment for a client with this dual diagnosis can begin, proper assessment is critical. According to Beasley, Kroll, and Sovner (1992) ensuring proper assessment is a "daunting task" for this population because the presence of mental retardation greatly complicates the diagnostic process (p. 56). As an example, diagnosing mental illness in persons with mental retardation does not lend itself to strictly the typical "office-based-fee-for-service" mental health practice (Beasley, Kroll, & Sovner, 1992, p. 56). Such assessment, instead, requires extended data collection, behavioral observations in natural environments, and multidisciplinary meetings to assess the degree of relevant signs and symptoms for diagnosis.

DesNoyers-Hurley and Sovner (1991) suggested two main differences in assessing and treating clients with mental retardation as compared to treating those with normal intellectual functioning. These authors stated that many assessment techniques and treatment strategies are designed for people who can identify abstract concepts, monitor and change their own behavior, and identify progress in their own interactions. Persons with lower cognitive functioning (the hallmark of mental retardation) simply do not possess these abilities for abstraction. Clinicians working with clients with mental retardation have to adapt their treatment strategies and assessments to the

cognitive levels of their clients. This generally requires, at the least, a return to much more concrete levels of communication as a base for all treatment.

The second difference in assessment and treatment, according to DesNoyers-Hurley and Sovner (1991) has to do with the client's motivation. Often clients with normal intellectual functioning are motivated through their own psychological pain to seek out mental health treatment. In contrast to this, persons with mental retardation rarely seek out treatment on their own. They generally are brought for treatment by caregivers or family members due to troublesome or dangerous behaviors they're exhibiting. Related to this is the fact that these clients often first appear at mental health centers in the throes of a crisis situation.

Sovner and DesNoyers-Hurley (1990) pointed to three additional issues which are critical for appropriate assessment. These include: (1) client self-reports are an unreliable way to collect diagnostic and treatment data; (2) consistent behavioral reports from family members and residential/vocational trainers are crucial; (3) knowing about behavior patterns over time is a critical factor in the diagnostic process and is necessary as a baseline for monitoring ongoing treatment (p. 91).

There are numerous objective instruments, including checklists and structured interviews, now available to assist in making proper assessments of mental health concerns in persons with mental retardation (Matson, 1992). Probably two of the most widely used measures of dual diagnosis include the Reiss Screen for Maladaptive Behaviors (Reiss, 1988) and the Psychopathology Inventory for Mentally Retarded Adults (Matson, 1988). Two other tools that may prove useful in holistic assessment of individuals with dual diagnosis include the Residential Services Indicator (Benson & McKinney, 1989) and the Apperceptive Personality Test (Karp, Holmstrom, & Silber, 1989).

Development of a Therapeutic Counseling Relationship

Baroff (1986) suggested three main treatment approaches to the amelioration of mental health problems in persons with mental retardation. He categorized these approaches as: psychotherapy and/or counseling, behavioral modification, and use of psychotropic medications. While all three approaches are widely recognized as effective, the efficacy of personal psychotherapy/counseling will be focused on in this article. A definition of counseling that seems to capture the inclusive aspects of counseling is the following provided by Gibson and Mitchell (1995):

> Counseling is a one-to-one helping relationship that focuses on a person's growth and adjustment and problem-solving and decision-making needs. It is a client-centered process that demands confidentiality. This process is initiated by establishing a state of psychological contact or relationship between the counselor and counselee and progresses as certain conditions essential to the success of the counseling process prevail. Many practitioners believe that these include counselor genuineness or congruence, respect for the client and an empathic understanding of the client's internal frame of reference. (pp. 31 and 32)

As a basic rule, mental health professionals providing counseling for persons with mental retardation need to follow carefully the relationship building components noted in the definition above and introduced many years ago by Carl Rogers. These conditions include the essential attributes of genuineness, empathy, and unconditional positive regard (Rogers, 1961). As Baroff (1986) noted, it is vital to the mental health of everyone, and

particularly appreciated by persons whose disabilities have typically evoked rejection, to be afforded a relationship that is accepting and relatively nonjudgemental in which to express feelings, ventilate frustrations, and begin to address problematic impulses verbally rather than acting out behaviorally.

Based on the Rogerian therapeutic relationship, DesNoyers-Hurley and Hurley (1987) derived nine basic principles which they recommended for the establishment of a therapeutic relationship for clients having both emotional disorders and mental retardation. These include: accepting clients as they are; understanding reality as the client sees it; accepting the life circumstances of the client; being consistent as a therapist (regardless of the client's varying moods and/or behaviors); separating therapy from other aspects of the client's life (avoiding dual relationships with clients); keeping the relationship totally devoted to the client; drawing the client out (helping the client be able to express him/herself through a variety of mediums); expressing genuine interest in the client; and finally, as a therapist, being a "real" person (pp. 15-19). The ultimate goal of such a therapeutic relationship is the development of trust so clients will feel freedom to discuss and explore feelings and situations before acting out through problematic behaviors.

Ensuring a Supportive Counseling Environment

In addition to the necessity of a strong therapeutic relationship, the counseling environment must be seen as supportive beginning with the initial interview. DesNoyers-Hurley and Hurley (1986) defined several tasks that are necessary in the initial counseling session as this first interview contact sets the stage for subsequent meetings. These key factors include setting a positive emotional tone for interactions, responsive and active listening, labeling feelings, and interpreting in understandable ways the client's statements and feelings expressed.

Several practical considerations and common courtesies have been found, in this author's experience, to take on even more importance and to be invaluable when working with this population. For instance, such seemingly minute concrete points as clearly letting the client know where and when the sessions will be held, keeping those appointments at the scheduled times, selecting a length of session appropriate for the client's developmental level and attention span, selecting a setting totally free of distractions, reviewing guidelines concerning confidentiality in concrete, understandable ways, not promising what you can't deliver, and most importantly, following through on any agreements you make with the client. These guidelines may take on a whole new level of significance when treating someone with lower levels of cognitive ability. From this author's perspective, the success of the therapeutic experience rests primarily on the therapist. Therapist genuineness seems to be especially critical. Persons with mental retardation seem to have a "sixth sense" in that they can readily tell if clinicians genuinely care about them - or are just doing "a job" to receive a pay check.

The counseling environment, in order to be truly supportive, needs to be flexible and responsive to the client. Attention to immediacy in the process is important and may take on new meanings when counseling persons with mental retardation. For example, if it is a beautiful day outside and the client is having difficulty remaining seated in the counseling room, why not take a walk or go sit outside under a tree while continuing the counseling session?!

Communicating with Persons who are Mentally Retarded

The counseling process, as known to mental health professionals, is highly verbal in nature. This is an important factor to consider when working with clients who may have limited, or no, verbal abilities due to their level of cognitive impairment. Related to this, Jay Haley (1976) discussed two general

types of communication: digital and analogic. He explained digital communication as typically being more precise, logical, rational, and concrete. Each statement in digital communication has a specific referent, and only that one. Something happens or does not happen. It is obviously a simpler, clearer form of communication. In contrast, Haley defined analogic communication as very abstract with multiple referents; the language of metaphors. In relating this background information to the topic at hand, any form of analogic communication is very difficult for clients with mental retardation due to their often limited cognitive abilities to understand abstraction. These clients have great difficulty, for example, with the meaning of proverbs such as "Don't cry over spilled milk" or "A bird in the hand is worth two in the bush". Counselors working with this population need to express themselves in very clear, concrete terminology that is appropriate for the cognitive level and verbal level of functioning of their client if any therapeutic intervention is to be successful.

Authors of the Criminal Offender Project in Duluth, Minnesota (1987) provided other important considerations for communicating with this special population. These considerations included: focusing on the "here and now" in concrete terms, focusing on the positive while giving directives, giving directions one at a time for tasks to be performed, checking frequently to see if the client is understanding what is being said, asking open, rather than closed-ended questions to assess understanding, not pretending to understand what the client is communicating if you don't, being patient, not giving choices of activities if you as a therapist are not prepared to permit the choice made, talking to (and never about) your clients, and finally, treating adults who have mental retardation as <u>adults</u>, not as children. As therapists, avoid talking down to people at all costs.

Specific Types of Therapies

Levels of mental retardation, obviously, have profound effects on any mental health treatment considerations. Also, as has been stressed previously, the essence of the therapeutic relationship is primarily the key factor in providing successful psychotherapy for persons with mental retardation. Within an established counseling relationship, more directive counseling and psychotherapy techniques are recommended (DesNoyers-Hurley and Hurley, 1986). Using a more directive approach the therapist, rather than the client, sets the agenda and objectives for therapy.

Since even recognition of a condition does not guarantee that appropriate treatment will occur (Thomas, 1994), education and training of community mental health care providers and clinicians regarding the mental health manifestations and needs of this population is a critical component of all service delivery systems (Beasley, Knoll, & Sovner, 1992). Such education may help in preventing crisis-precipitated interventions which, unfortunately, are all too often the client's first contact with mental health services.

Preventative education and training is often appropriate for the clients themselves. As examples, anger management training (Benson, 1986) or group experiences in learning about feelings (Ludwig and Hingsburger, 1989) or dating skills (Valenti-Hein, 1990) can be valuable experiences. Alternative therapies include focusing on the creative arts. Art and music therapies have been successfully incorporated into treatment planning as has recreation therapy (Thomas, 1994).

Individual psychotherapy is often the method of choice for therapeutic interventions for this population, but as Baroff (1986) noted, the therapist/client relationship need not be a one-on-one experience. Often group therapy is more effectively used offering a safe, controlled setting for

examining interpersonal relationships and developing awareness of how one's behavior may affect others. Fletcher (1984) outlined both rationale and strategies for providing effective group therapy for mentally retarded persons with emotional disorders. Clearly, in considering treatment, counselors need to know the accepted treatments for psychiatric disorders in the normal population and then apply such treatments, possibly with necessary modifications, to persons with mental retardation.

Conclusion

Thomas (1994) stated that the current status of service delivery for persons with the dual diagnosis of mental retardation and mental illness is unacceptable! Services for this population have been sorely lacking as they've often not been a high priority for service providers (Matson, 1992). Matson (1992) further suggested several mental health issues in normalizing services for persons with mental retardation. He noted that services for these clients should certainly be as available as are those for everyone else in communities. Such services should include a right to effective mental health treatment, available support services, psychological support for families, informed consent for services, multiple opportunities to succeed, and professionals allowed to make clinical decisions based on the clients' needs.

In the future, as more and more persons with this dual diagnosis are mainstreamed into communities across the country, it will become crucial for mental health service providers to have an understanding of dual diagnosis issues and concerns. Education and training of service providers is crucial. Additionally, more research in this area needs to be done as we move into the 21st century.

In conclusion, England (1992), in looking ahead to the 21st century, remarked: "We have made significant scientific and medical changes in this

century; we have not made the same leaps in taking care of the human condition. Let's look at the 21st century, let's take the things we have learned and make them even better" (p. 89). As mental health professionals, the challenge is ours to encourage pluralism and diversity and to deliver better mental health services to all special populations within our own communities.

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